Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2015	2015_190159_0001	H-001912-15	Complaint

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON MEADOWS
215 Sunny Meadow Blvd. BRAMPTON ON L6R 3B5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Janauary 27, 28, 29, 2015

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, RAI Coordinator, Registered staff, Registered Dietitian, Personal Support Workers(PSWs), dietary staff and residents.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Home's policy # V9-251 tilted "Hydration Management Program directs staff to: If a resident has not consumed at least 12 servings (75%) of the fluid provided at meals and snack by the home's menu for 3 consecutive days, the Registered Nurse will review the care plan to determine if the resident has individualized daily fluid goals and if so assess if the resident is meeting his/her individualized goals or does not have individualized fluid goals indicated on the care plan, the registered nurse will initiate a hydration program as outlined in either A or B.
The policy further directs the staff that the Registered Nurse would initiate a dietary referral for each resident who has not consumed 12 x125ml servings of required amount of fluids for the 24 hour period over a three consecutive days.
Review of fluid intake reports for resident #001, #002 and resident #003 indicated residents consumed most days less than the established fluid target of 12 servings (1500ml) of fluids a day.
Resident #001 fluid intake record for December 2014 and January 2015 indicated several consecutive days resident consumed less than 12x125ml=1500ml/day. On Specified dates in December 2014, resident's fluid intake for five consecutive days was less than 12x125ml/day. In January 2015, on specified dates resident's fluid intake report indicated resident consumed less than 10x125 ml/day for four consecutive days. The registered staff confirmed a dietary referral was not made when the resident was identified at risk for dehydration. The home's policy for hydration management was not complied with.
The fluid intake report for resident #002 indicated most days resident's fluid intake was less than 50% of the assessed fluid needs. The fluid intake record identified on specified

dates in December 2014,for five consecutive days resident consumed less than 8x125 ml servings of fluid /day. The home's policy stated all residents would be offered a minimum of 16X125 ml servings of fluid daily.
For Resident #003 Point of Care (POC)food and fluid intake record indicated resident's fluid intake on specified dates in January 2015, was less than 12 servings a day for five consecutive days. Record review and interview DOC confirmed a dietary referral was not made. This was further confirmed by the registered dietitian. Home's hydration management policy was not complied with.
The home's Hydration Management policy further stated that: PSW will report to the nursing staff member assigned to the home if resident has not consumed the recommended 12 servings (1500 ml) of oral fluid a day for three consecutive days. The Inter-professional team will initiate a hydration program as per Hydration Management Program Policy (V9-251).
Food and fluid intake record for resident #001, #002 and #003 indicated residents consumed less than the recommended 12 servings of fluids a day for several consecutive days. Interview registered nurse confirmed the Personal Support Worker (PSW) did not report to the registered staff that the identified residents consumed less than the recommended servings of fluid. Review of Point of Care(POC)fluid intake record and interview Director of Care confirmed resident #001, #002 and #003 did not meet the fluid intake requirement for several days and the Inter-Professional team had not initiated a hydration management program. The registered nurse assigned to the home area confirmed the identified residents at risk for inadequate hydration did not have hydration program to prevent dehydration. Hydration Management policy was not complied with for resident #001, #002 and #003. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Registered Dietitian (RD) who is a member of the staff of the home assessed resident #001 hydration status and any risk related to hydration.
The progress notes documented in December 2014 by Assistant Director of Care (ADOC) indicated a dietary referral was made to the registered dietitian. The documented reason for the referral was change in resident's condition, poor food intake due to medical condition.
In December 2014, on a specified date the registered dietitian had documented in progress notes that resident was consuming 50% of food,supplement and average 10 serving of fluids. The registered dietitian changed the nutritional supplement servings but did not assess resident's hydration status. Resident was identified to be at risk for dehydration due to medical condition and inadequate fluid intake. In January 2015, the Nurse Practitioner (NP) had assessed the resident and ordered medical interventions. However, resident did not have an interdisciplinary hydration assessment and interventions.
For resident #001 Minimum Data Set (MDS) collected in January 2015 indicated Resident Assessment Protocol (RAP) was triggered for Dehydration/Fluid Maintenance. The RAP summary documented by the registered dietitian on a specified date in January 2015, identified resident's fluid intake did not meet the estimated fluid requirements of 13-15 servings a day. However, the RAP summary did not include interventions and strategies to minimize the risk for dehydration. The registered dietitian documented in the progress notes that the resident's fluid intake was inadequate due to a medical condition. Resident remained at high risk. However, documentation in the point click care did not include hydration assessment and individualized interventions were not developed to meet assessed hydration needs. The clinical record and the interview with the registered nurse indicated the resident had a significant change in health status. The registered nurse and the DOC confirmed that the resident did not have an interdisciplinary hydration assessment and interventions/strategies were not initiated to address resident's hydration concerns. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures a registered dietitian who is a member of the staff of the home, (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4). r. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home, (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's record is kept up to date all times. Resident #001, resident#002 and resident #003 did not have food and fluid intake consistently recorded. A review of the food and fluid intake records for December 2014 and January 2015 were found incomplete and /or inaccurate. Several entries were missing and inaccurately recorded.
Resident #001's meal consumption report for December 2014 and January 2015 had thirty meal, snacks and fluids intake entries not recorded. Examples:On specified dates in December 2014, food and fluids intake was not recorded.
Resident #002 did not have food and fluids intake recorded consistently. In December 2014, and January 2015, on specified dates the food and fluids intake was not recorded. Elven entries were missing.
Resident #003's food and fluids intake was not recorded on specified dates in December 2014. Twenty two meal, snacks and fluid entries were not recorded. This was confirmed by the Director of Care and the Registered Dietitian. [s. 231. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures(a) a written record is created and maintained for each resident of the home; and (b) the resident's written record is kept up to date at all times, to be implemented voluntarily.

Issued on this 23rd day of February, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.